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Genitourinary medicine?

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> 'When *I* use a word', said Humpty Dumpty in a rather scornful tone, 'it means just what I choose it to mean—neither more nor less.'
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> *Alice Through the Looking Glass*

Historical background

In 1916 the Venereal Disease Regulations defined three venereal diseases, syphilis, gonorrhoea, and chancroid, and clinics for their diagnosis and treatment were established. In the pre-antibiotic era much expertise was needed, The arsenicals used for the treatment of syphilis were given intravenously once or twice a week for many months, and local and systemic reactions from these toxic drugs were frequent, requiring skilled management. Late syphilis was common and presented a further series of diagnostic and therapeutic problems. In the treatment of gonorrhoea in men intraurethral irrigations, although largely ineffective, nevertheless needed expert nursing care; furthermore, the management of local complications, common in those days—such as epididymo-orchitis, prostatitis, and periurethritis with ensuing urethral stricture—all required medical and nursing skills of a high order. For reasons which are not clear chancroid fairly rapidly dropped out of the picture and is now a very rare infection in Britain.

The pioneers of clinical venereology, dealing with the designated venereal diseases (DVD)—in effect syphilis and gonorrhoea—rose to these challenges and throughout the 1920s and 1930s became unrivalled in this difficult but rewarding field. However, with the introduction of penicillin in 1943 the therapeutic situation was revolutionised. Syphilis could be cured with a course of treatment lasting for two weeks or less, and in the ensuing years the prevalence of its late manifestations declined. Gonorrhoea usually responded to a single injection, and the acute local complications became rare. Many of the technical and medical skills of physicians and nursing staff were no longer needed, and the end of venereology as a rewarding, or indeed a necessary, specialty was confidently predicted. Nevertheless, clinics continued to function. They were convenient for patients, who appreciated the kindness and confidentiality with which their problems were handled; the monitoring of the results of the treatment of gonorrhoea was possible and became essential as antibiotic-resistant strains of *Neisseria gonorrhoeae* began to emerge; epidemiological control through systematic contact tracing was gradually developed and research into all aspects of DVD pursued. Within the clinic system it thus became possible to establish standards of the highest quality.

Throughout the pre-antibiotic era patients attended clinics with diseases other than the DVD. Non-gonococcal urethritis (NGU), condylomata acuminata, *Phthiris pubis* infestations, scabies, and trichomoniasis were all well known and were treated as well as possible with the limited resources then available. But these 'other' diseases were not regarded as important compared with the DVD, for which the clinics had been established.

The present-day situation

The situation today is very different from that which existed during those early years. In Britain syphilis is now an uncommon disease, although early diagnosis, effective treatment, and epidemiological control remain important. Late syphilis is rare and falls almost exclusively into the care of the general physician or surgeon, the advice of the venereologist being needed only on antibiotic therapy or on the interpretation of serological tests. Gonorrhoea, on the other hand, is very common, but its effective management depends more on applied microbiology and the application of control measures through contract tracing than on great experience or skill on the part of the physician. The effects of these diseases on the patient's personal relationships are, as always, of great importance and will be discussed later. Nevertheless, a physician today

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whose clinical work was restricted to the DVD could be forgiven if he sometimes found his duties a little dull.

That this is not so in present-day practice is due to the existence of those 'other' conditions (other than DVD, that is), formerly dismissed as of little importance but now increasingly realised as presenting a massive challenge to physicians interested in genital tract disease. In most clinics in Britain the DVD are found in about one quarter of new patients, but one or more of the 'other' conditions are present in one half. Of these conditions, NGU and its related syndromes in women (so-called 'non-specific genital infection') are the most important. NGU is twice as common as gonococcal urethritis. About 50% is caused by *Chlamydia trachomatis*, and this organism may also cause epididymo-orchitis in men, cervicitis and salpingitis in women, and ocular infections and interstitial pneumonitis in neonates; and thus it is potentially as pathogenic as the gonococcus. NGU itself is notoriously liable to recurrence; it may be complicated by prostatitis or urethral stricture, and many men spend literally years in clinic attendance with consequent devastating effects on their morale and psychosexual function. Genital herpes is another disease liable to frequent recurrence and with the potential for causing neonatal infection; in addition, the possibility of a causative association with cervical carcinoma has posed problems in the long-term follow up of women. Genital warts are sometimes regarded as just a nuisance, but completely satisfactory therapy has never been devised, and the amount of time spent on their treatment is enormous; they are (rarely) liable to malignant change. NGU, genital herpes, and genital warts are all sexually transmitted diseases. The natural history of vaginal candidosis, is, however, quite different. This is the commonest genital infection in women attending clinics, and because of frequent recurrences poses many problems to patients and physicians alike. Unlike the DVD candidal vaginitis does not normally occur by infection during sexual contact, although it is sometimes transmitted from a woman to a male partner.

Of the remaining 'other' conditions encountered in clinics, trichomoniasis occasionally presents problems through treatment failure, but *Phthiris pubis* infestations and scabies are simple to treat, and molluscum contagiosum is unimportant. There remains a group of disorders whose status is uncertain. The aetiology of so-called 'non-specific' vaginitis, and of much balanoposthitis, is undetermined; if they are infections the causative organisms are unknown. Some patients present with dermatoses with genital manifestations, and others with miscellaneous non-infective genital disorders such as lymphocele and lichen sclerosus. Finally, many men and women attend clinics with symptoms which are an expression of an underlying sexual dysfunction.

Future of clinical practice

The realities of clinical practice today are thus far removed from those which existed when the clinic system for DVD was first established, and over the years the system has been modified to meet these new demands. Bearing these in mind, it is worth attempting to appraise the areas of medical practice with which the clinics of the future should, and should not, be concerned. The DVD must of course be treated here; every argument from clinical practice, microbiology, epidemiology, and research supports this. Those 'other' diseases already discussed should also be managed in clinics. In particular NGU, genital herpes, genital warts, and vaginal candidosis—because of their formidable problems—require the attention of experienced and knowledgeable physicians. In fact their practical management is far more difficult than is the case with the DVD.

Trichomoniasis, molluscum contagiosum, *Phthiris pubis* infestations, and scabies hardly require specialist treatment, although since they may be associated with more serious infections they are also probably best managed in clinics. Exotic sexually transmitted infections, such as lymphogranuloma venereum, granuloma inguinale, and chancroid, are occasionally introduced into Britain and should likewise be treated in clinics, although it must be admitted that only a few physicians have much experience of these conditions. It is suggested that the miscellaneous genital tract disorders described above, including those of uncertain aetiology, are also best managed by physicians in clinics, since progress is more likely to come from those who already have a wide knowledge of the field.

It is not suggested that *all* disorders of the lower urogenital tract should be investigated and treated. Urinary tract infections, although sometimes sexually associated in women, fall within the province of the urologist. Treatment of male infertility requires endocrinological and surgical skills which the clinic physician does not possess. Bladder neck disorders and perhaps chronic prostatitis are likewise the concern of the urologist. Vaginal discharge due to non-infective cervical disease, and structural and endocrinological disorders of the female genital tract, are likewise the concern of the gynaecologist.

The feelings of guilt and remorse traditionally associated with DVD are very real but are also experienced by those with other infections or indeed with no disease at all. These feelings may merge into a depressive state, and suicide has occurred. In some patients repeated attacks of genital infection are the expression of a personality disorder, and in others an excessive preoccupation with DVD in the absence of such infection (loosely described as 'venereophobia') is due to a paranoid or other psychosis. To disentangle these various states and to decide which patients need psychiatric advice is an important task for the physician.

A separate but no less important problem occurs in a group of patients who increasingly turn to clinics for help with sexual dysfunction. Erectile failure or premature ejaculation in men, for example, may be the real reason for symptoms with no organic basis; sometimes a genital infection may have been acquired in a desperate attempt by a man to 'prove' his virility with a casual acquaintance, and sometimes an explicit request for help with a psychosexual problem is made. Similarly vaginismus and orgasmic dysfunction in women are often revealed as the true reason for genital symptoms. These disorders are of great importance, and it is often difficult for patients to know where to turn for help. While it is not suggested that their treatment should be undertaken in all clinics there are already physicians with special knowledge and experience in this area, and there may well be more in the future who will wish to use their skills in clinics. All physicians in the field should at least be able to assess which patients require simple counselling, which need advice from an expert on psychosexual problems, and which need formal psychiatric help.

Of the social services available in clinics, contact tracing is an essential part of the management of any sexually transmissible disease. The present area of operation of social health workers is, however, too limited and should be expanded to include patients with NGU; the importance of this in genital infections by *Chlamydia trachomatis* is already well known. Further extension of contact-tracing action to other diseases known to be sexually transmissible appears to be a desirable long-term goal. The role of medical social workers is more difficult to assess. Patients attending clinics, like other patients, may have social problems of various kinds, and access to the appropriate agency is necessary. Whether medical social workers should become involved in marital or psychosexual problems is debatable; many would feel that these matters are primarily the concern of the physician.

Changes in terminology

The clinics originally organised to deal with DVD are now concerned with a wide range of sexually associated disorders, and there will be even more in the future. How are these disorders to be classified, and what collective name should be given to them and to those who study them? Syphilis, gonorrhoea, and chancroid are the legally defined venereal diseases, but by definition 'venereal' is synonymous with 'sexually transmitted'. Since 1971 the Department of Health and Social Security in its statistical returns has abandoned the term 'venereal diseases' and substituted 'sexually transmitted diseases' but has continued to report the same wide range of genital infections. It is hard to follow the logic of this unless it was an attempt to abandon a term with inescapable moral and legal overtones. But many problems and paradoxes remain. In what sense, for example, is vaginal candidosis a sexually transmitted disease? Its natural history is quite unlike those of the DVD. Is NGU a 'venereal disease' in exactly the same sense as gonorrhoea? Further, the sexually transmitted, or transmissible, diseases (however loosely defined) do not, as has been seen, by any means comprise the whole of clinical practice within the specialty.

It was in an attempt to resolve these problems that it was suggested that a new name for the specialty was needed, and 'genitourinary medicine' was recommended. A heated public debate followed. Objections came from two sides. Some urologists believed that the term might imply that clinic physicians could become involved in the management of urinary tract infections, male infertility, and other urological disorders which they had not the qualifications or experience to manage. It has already been argued that these disorders do not, and should not, form any part of the specialty under discussion. The objections to 'genitourinary medicine' voiced by many physicians working in this field were more serious, as these were not about words but implicitly about the whole future trend of the specialty. It was feared that if the new term were to be adopted DVD would in time be regarded as of secondary importance, to be left to junior staff, while senior physicians became involved in clinical matters which were really none of their concern. It was further claimed that the time-honoured term 'venereology' was still adequate to describe the work conducted in a modern clinic. But the importance of any disease lies in the clinical and social problems which it causes, and to take a one-sided view of the specialty is ultimately harmful to patients. Of course, the DVD are important, but there are many other disorders (both infective and

non-infective) in patients attending clinics which are of no less importance. To think that, say, recurrent vaginal candidosis which has led to a severe psychosexual disorder is less important than gonorrhoea is as absurd as to think that molluscum contagiosum is more important than syphilis.

The term 'venereology' is hallowed by tradition, but is it really adequate for modern practice? The answer must be no, unless the meaning of words is stretched beyond recognition. If the specialty were concerned only with sexually transmitted diseases, what is the status of patients without these diseases? Might *they* not be regarded as having conditions of little importance? If only patients with DVD are included the clock would have been put back 60 years. 'Genitourinary medicine' is an appropriate term, but it is not synonymous with 'venereology'; it symbolises a different and, it might be thought, more mature and realistic view of the specialty.

The past is dead. It can be remembered but not resurrected. Clinical, microbiological, epidemiological, and social problems abound, but they are not the same as those of 50 years ago. In considering the services provided in clinics today and in the future—whatever name appears on the door outside—it is essential to define the areas of importance, some old but many quite new, in the expectation that physicians and other workers will maintain, or exceed, the high standards of their predecessors to the benefit of every patient.